VAIL CHRISTIAN ACADEMY
Life Preparatory School

Physician Statement of Need

Student's Name _____Birthdate _____

Student's Address_____

School_____Grade_____

Medication to be administered_____

Does this medication have a generic name also? _____

Dosage to be administered _____

Time or interval at which each dosage is to be administered _____

Date to begin administration _____

Date to cease administration _____

Possible adverse reactions _____

_____

List of severe reactions that should be reported to the physician_____

_____

Special instructions for storage of medication _____

_____

Special instructions for administration of medication _____

_____

Physician's name _____

Physician's address_____

Physician's phone number _____

Emergency contact information for physician _____

_____ _____

Physician's Signature Date